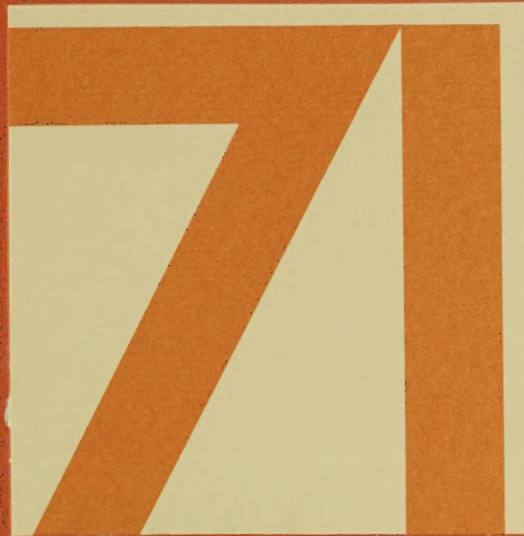
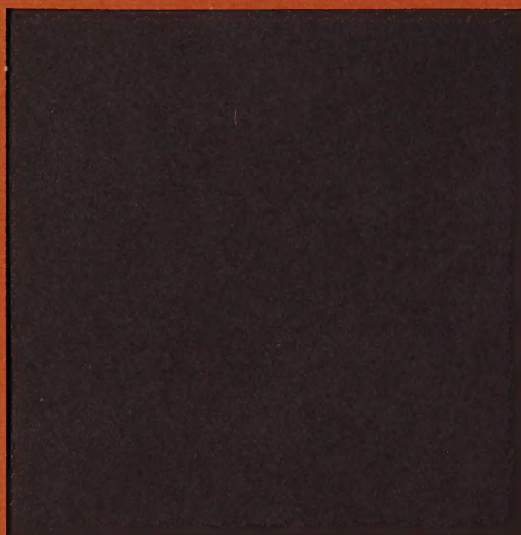


NEW
ENGLAND
DEACONESS
HOSPITAL
ANNUAL
REPORT





NEW
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DIRECTORY

MARCH 1972

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ADDITIONS

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THE NEW ENGLAND DEACONESS HOSPITAL

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fully accredited by:

THE JOINT COMMISSION ON
ACCREDITATION OF HOSPITALS

member of:

AMERICAN HOSPITAL ASSOCIATION
NEW ENGLAND HOSPITAL ASSEMBLY
MASSACHUSETTS HOSPITAL ASSOCIATION
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residency programs approved by **AMERICAN MEDICAL ASSOCIATION:** *internal medicine, pathology, radiology, surgery and thoracic surgery.*

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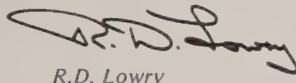
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1971 ANNUAL REPORT

With the compliments of the
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R.D. Lowry
Executive Vice President

no acknowledgement necessary

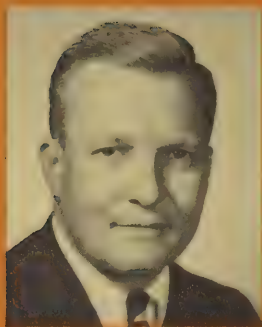
NEW
ENGLAND
DEACONESS
HOSPITAL



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REPORT OF THE PRESIDENT

Laurens MacLure
President



Traditionally, an annual report resembles a two-way mirror. It is designed both to reflect in proper perspective the important events of a year just ended and, also in proper perspective, show the challenges ahead.

Such an approach seems particularly appropriate this year which marks the 75th anniversary of the New England Deaconess Hospital. The present day Deaconess with its 500 beds, 2000 employees, extensive support facilities, and educational programs is far removed in many respects from the 14-bed hospital staffed by eight Methodist Deaconesses in 1896. In essence, however, the identity remains. We share the same concern for the sick and still look with vision to the future.

The last 12 months have been most difficult, yet in the end they made up one of the most rewarding periods for the Deaconess in recent years.



First, after frustrating delays, the six-story, 220-bed addition to the Central Building was completed. One new floor was phased in each month as the year progressed. By mid-summer all the new floors were in operation and the contractor turned his attention to the many renovations, large and small, which were needed to complement our new patient-care facilities. By year end these tag ends were well tucked up and it could finally be said that Phase I of our Development Program, which began five years ago, was successfully completed.

The transition from 370 to 500 beds was accomplished during the year, but not without strain on all departments of the hospital. The new demands had been largely anticipated, however, and therefore were successfully dealt with. Nevertheless, the economic strain was rather difficult.

We knew from the outset that we were faced with a 25 per cent increase in operating expenses, largely salary expense associated with the staff additions required by the additional beds. Unfortunately, however, the delays in opening the new floors resulted in a significantly higher level of expenses without offsetting revenues. Also, during the summer months, our occupancy rate fell below 90 per cent for the first time in about ten years. This combination of circumstances led to an operating loss of \$414,000.

Economically speaking, 1972 starts with considerably more than the usual degree of uncertainty. On the positive side, our occupancy levels have recovered. On the other hand, Phase II of the President's economic program leaves many questions regarding wage and price policies as they affect hospitals. Our budget committee has approved a balanced budget for the current year and we are hopeful

that we will be able to meet our income and expense projections. With Phase I of our Development Program completed, we are, of course, already embarking on Phase II.

During 1971 we completed the tunnel running under Joslin Park and Brookline Avenue. The tunnel connects the Deaconess to the Shields Warren Radiation Laboratory. This physical link not only will contain our steam and chilled water lines, but will make it far easier for doctors and students to move from one institution to another in this area. Equally important, the tunnel will permit patients to be shifted to specialized facilities that may be developed in the future.

In September we broke ground for a new 415-car garage which is scheduled for completion by the end of 1972. This new facility will improve the availability of adequate parking space for our patients, visitors, and employees.

Our building committee continues to work on two additional projects: new quarters for our school of nursing, and a new laboratory building which will be designed to house a radiation therapy facility in the basement.

Now to look ahead for a moment. We who serve as Trustees and Corporation members of voluntary hospitals realize that profound changes are taking place in our society in general and in the health care system in particular. Hospitals are largely dependent on third-party payers today for the greater part of their income. Because of this dependency and because hospitals are responsible to a growing number of regulatory bodies, accounting procedures are complex. Since costs have been rising rapidly, we may soon find ourselves being told how to run our hospital and whether or not we can expand our facilities or services. At the same time, it has become generally accepted that every citizen is entitled to good health services.

Under these circumstances, it is not hard to make two predictions: first, the health care system with which we are familiar is going to change, perhaps significantly; second, hospitals will become, as many knowledgeable people believe, the center of a revised health system.

It is with these concerns in mind that we retained a professional consulting firm to assist our long-range planning committee. These concerns also motivated discussions with Lahey Clinic earlier this year. The report on the Lahey Clinic discussions will be referred to our long-range planning committee for further study in the light of alternative proposals which will be contained in a report being prepared by our consultants.

These are challenging and exciting times. However, I feel certain that the Deaconess will be well served, as it plans for the future, by a knowledgeable and dedicated team comprised of Trustees, Medical Staff, and Administration.

My report would not be complete without a sincere expression of deep appreciation to our staff, doctors, nurses, technicians, and all of the others whose combined efforts contribute to the healing and comfort of our patients. Mr. Lowry, Mr. Lee, and their associates deserve a special word of thanks for the outstanding job they have done during the year just ended.

REPORT OF THE EXECUTIVE VICE PRESIDENT

R.D. Lowry
Executive Vice President



Someone once said that the first 100 years are the hardest. The Deaconess Hospital has now completed 75 years of service, and because of changing times, it is apparent that the years immediately ahead of us may be the most difficult in the hospital's history because of the major decisions that must be made — decisions that may alter the character of our hospital. While the hospital has operated in a relatively unchanged system for 75 years, there is little possibility that we can continue to operate as we have in the past.

Let us briefly review the history of our hospital. Since its doors were opened in 1896, there have never been enough beds to meet the demand. The long list of patients awaiting admission has caused many serious hardships for the patients, difficulties for the medical staff, and unusually heavy pressure on personnel of the hospital who have had to cope with the high percentage of occupancy.

A few years ago a consultant gave a report to the Trustees after having made an in-depth study of the hospital, its physical facilities, the composition of its medical staff, and the long list of patients awaiting admission. In capsule form, the report stated that either the hospital's size would have to be increased to meet the demands facing it or some members of the medical staff would be forced to turn elsewhere for patient-care facilities. New physicians appointed to the staff were often unable to get beds for their patients and many of them were forced to accept the fact that, regardless of their wishes, they would be unable to adopt the Deaconess as their primary hospital. Concurrent with the consultant's report, the Massachusetts Department of Health declared that the Deaconess building, which housed almost one-half of our medical and surgical patients, was obsolete.

With the aid of funds received from a capital funds campaign,



bequests, and outside financing, the Trustees approved embarking upon a construction program which would replace the 140 obsolete beds and add about 100 new beds. The building program is almost completed and our hospital now has approximately 500 beds making it the third largest acute medical and surgical hospital in Boston.

During the past year the increase in the number of beds has caused severe growing pains in most departments of the hospital. Fortunately, we were able to obtain an adequate number of nurses and to find personnel for most of the other departments. However, training new personnel to perform in the "Deaconess way" of giving patient care, adapting to the new and larger patient floors, and the sheer increase in the volume of work in all departments has made the past year memorable particularly because construction was still underway in both patient and service areas.

Now, in our 75th year, we have a large and busy hospital with an ever-increasing outpatient load, a doctor's office building which provides space for 75 busy physicians, a motel, research buildings and other facilities located on 7.5 acres of land adjacent to streets that are operating at capacity as far as automobile traffic is concerned. It is apparent that any further increase in the number of beds (if an increase should become highly desirable at some time in the future) will be impossible. At the present time many supporting departments need space for expansion, and the hospital is under almost constant pressure for new or additional services which are not available in the immediate area. In addition, the new beds in the Central building have made some of the beds in other buildings seem far less desirable than they were just a year ago, and these facilities must be upgraded.

There has been much discussion about the possibility that there are

too many hospital beds in the area. While there may be an element of truth in this conjecture, our hospital has for many years and is still experiencing one of the highest percentages of occupancy in the city.

With the Joslin Clinic, Lahey Clinic, Overholt Clinic and a large independent medical and surgical group, the hospital has had a unique medical staff. Now changes are in the wind. The Lahey Clinic, for years seriously handicapped by lack of space in its present location and by a shortage of hospital beds, is attempting to relocate and build its own hospital. It is possible that their need for beds in the Deaconess may diminish in the years ahead. In addition, there is a decline in the number of doctors finishing their residencies who want to go into independent practice. The number of doctors graduating from Harvard Medical School who want to get away from the fee-for-service system and join a salaried system was 61% in 1971 as compared with 4% in 1959. Most younger doctors are interested in either group practice or in becoming hospital based. It is apparent that the two factors above could have a great impact on our hospital.

The most important factors which will affect the future of our hospital are the change in the public's attitude and the young physicians' attitudes toward our present health care system. The heated criticism of the health field and the numerous proposals for sweeping changes in the organization of health services are causing anxiety and great uncertainty in the minds of many. A survey of the 1971 graduating class of Harvard Medical School revealed that 86% were unhappy with the current methods of delivering health care. Only 9% expressed this opinion in 1959. A total of 81% of the graduating students supported creation of some form of National Health Insurance, and 98% believed that groups of doctors representing a range of specialties was the best way of delivering health care.

We are all aware of the numerous plans that have been proposed for national health care, and no one can be certain which method may be adopted. Whether the plans will be on a practical basis or on a political basis is cause for concern for everyone. This much does seem certain — if the pleas of the consumer are heeded, whatever plans are finally adopted will have to guarantee the majority of the people in our country a total health care package paid by some form of insurance.

Where the New England Deaconess Hospital will fit into the health-care programs of the future cannot be predicted at this time. Since the Deaconess is a rather highly-specialized hospital that serves patients from a wide geographic area rather than a community hospital that basically delivers primary patient care, our problems are somewhat unique. The Long-Range Planning Committee has a monumental task cut out for itself in its attempts to make sound recommendations to the Board of Trustees.

In the back of this annual report is our financial statement for the past year showing our assets and liabilities. However, the most valuable asset of any organization is never shown on the balance sheet and that asset is, of course, people. This has been a trying year for Trustees, Medical Staff, Administration and all personnel of the hospital. Because so many, during this period, have given of themselves far above and beyond the call of duty, it is impossible for me to single any individuals or groups for special commendation. Let me close by saying that I am honored to have the privilege of working with all of you.

REPORT OF THE DEPARTMENT OF MEDICINE

James L. Tullis, M.D.
Chairman



The medical profession often comes in for criticism: some merited, some not. To its credit it seldom can be accused of intellectual stagnation. Although occasional members fail to keep up with the spate of new knowledge that floods in from every side, the time-honored rationalization of being "too busy" gives promise of fast disappearing from the contemporary scene.

In several states throughout the country proof is being demanded that physicians continue their exposure to education and new knowledge. The demand has taken at least three different forms: (1) legalism, as in a requirement of annual relicensure; (2) social pressure, as in medical society bylaws, and (3) economic clout, such as evidence of participation in refresher courses in order to qualify for third-party insurance fees. Although these pressures are shared by all types of doctors, it is the internist and the medical sub-specialist who is destined to feel them most in the decade ahead.

The amount of new information an internist or sub-specialist must encompass each year is disproportionately large. Simultaneously, the amount of time available to him

for scholarly pursuits shrinks with each new regulation and code imposed on his practice by third-party agencies and government. This makes him an easy prey of frustration as he attempts to keep up his reading, writing, and attendance at conferences, seminars and rounds. As in many human endeavors, those who participate in education the least are sometimes the ones who need it most. This observation has stimulated one medical teacher (Park J. White, M.D.) to write:

Emeriti at Grand Rounds

Teeth, hair are gone,
But we're not done
With trying to make like cerebration.
Our science gaps
Produce relapse
At every new, complex equation.

Friends do dire things
With benzene rings;
We reel at th' blackboard's *danse macabre*
In vain we trace
Transaminase
Enzymes that branch like candelabra.

What? Only praise
Those bygone days
When tests are few and treatment hoary?
No! Yet shall we
The sick, hear, see,
But not ignore —
Nay, bow before — that laboratory.

In Massachusetts the direction which obligatory, continuing medical education will take is as yet uncertain. Two facts emerge, however. Firstly, such instruction will remain as individualistic and non-regimented as possible without attracting national attention. Like double parking, it may appall all new arrivals to this region before they appreciate that in the end it works satisfactorily most of the time. Secondly, it will be exciting and diverse. The high level of medicine practiced here continues to attract students and investigators from all America. They come seeking excellence. It behooves us to continue to supply it, even if this someday may require regulatory standards as rigid as the customary standards for intern and residency training.

A considerable amount of medical education for practicing physicians already is in progress at the Deaconess. For years the Joslin Clinic has sponsored seminars on Diabetes as part of a Harvard program of post-graduate training. The Lahey Clinic was one of the first institutions to be approved formally for similar courses for physicians. This coming year an interdepartmental committee of the Deaconess is conducting a comprehensive seminar on Newer Concepts of Cancer Management as part of a Harvard sponsored program. In order to fulfill the Deaconess Hospital's potential in this field properly, and at the same time prepare for a day when accreditation may begin, a whole new department or section of the hospital may need to be established.

Meantime, what other forces are beginning to surface in the Department of Medicine? Prominent is a desire among many members of the staff to extend their healing arts to a broader segment of society. In part we can thank youth for lifting us from the mire of complacency. It is primarily the new and younger men of medicine who are demanding that the professional career upon which they have embarked have constant relevancy to their

community. One such outlet which has appealed to many who apply here for house officer training has been the joint program with the Children's Medical Center to train family physicians. As part of this four-year program, each young doctor has been assigned a quota of families from economically deprived areas of the city. He has then remained the entry point into the health care system for such families throughout his training. With the recent cut-back in federal funding, this most valuable program is in danger of disenfranchisement for the Deaconess. Those of us who understand the limitless potential it has for the practice of medicine in the coming generation must not let it be extinguished.

Within the hospital itself, service to the sick has continued to improve. The opening of the final floors of the new building has helped immeasurably to centralize medical care. The enlargement of the intensive care area, especially for coronary monitoring, has extended greatly the ability to offer this often life-saving supervision to all who need it.

The next goal on the medical horizon, however, should not be an ever-widening circle of intensive care. Such programs inevitably reach a point of diminishing return. Rather, it should be the provision of "grouped" care for the confused patient or the post-stroke patient or the simple elderly person who may be too feeble to care for himself. In a setting of private and semi-private accommodations such as have been demanded by the public today, it is virtually impossible for a small group of nurses or doctors to give the constant overview that was possible in the open medical wards of old or in the intensive care areas of today. Hence, the sick person denied entrance to an intensive care unit because he may not have a salvageable disorder may be a less glamorous case than a post-renal transplant or open heart surgery, potentially may suffer from serious neglect.

The distress of an elderly patient, confused and in strange surroundings, fumbling with the many buttons and dials which project from his bed, may outwardly appear to have comic proportions. But to him it is terribly important whether he presses the button which summons a nurse, elevates the wrong end of the bed or turns on a color television set which he is too myopic to see. Even a tray of food brought to a room where the patient hasn't the strength or knowledge to feed himself can constitute an emotional crisis. Compassion demands that we make open ward areas available once again for appropriate succor and support of this small group of overlooked patients.

Finally, the Medical Department needs to strengthen the balance of its senior staff and actively extend sub-speciality recruiting to areas such as infectious disease and pulmonary function. With vigor and enthusiasm we must meet these ever-changing requirements of the future.



REPORT OF THE DEPARTMENT OF SURGERY

Cornelius E. Sedgwick, M.D.
Chairman



Annual Reports from the Department of Surgery in past years were concerned primarily with reviewing our progress in developing teaching programs such as those involving residencies for post-doctoral training in General Surgery, Neurosurgery, Ear, Nose and Throat and Urology. Also reported has been our close affiliation with Harvard Medical School, offering instruction in clinical general surgery to increasingly larger groups of second and third year medical students.

In this year's annual report it will be perhaps more useful and informative to place the emphasis elsewhere. But first, a brief updating of the teaching programs.

We have continued and strengthened our teaching programs relative to paramedical personnel. In September seven persons were graduated from our Department of Respiratory Therapy and seven from our School of Operating Room Technicians. This past year for the first time, 13 affiliating student operating room technicians from the Dimock Community Health Center in Roxbury were given clinical experience in the Operating Rooms. The students were supervised and instructed by Miss Diane Gulczynski, C.O.R.T., who is a member of the New England Deaconess Hospital Operating Room Staff. Members of the Surgical Staff, doctors and nurses are to be commended for the excellence of this program.

The subject I would like to emphasize this year, and to support with some interesting statistics, is the variety of types of surgery done at Deaconess and the cost to the hospital they entail, compared with

the costs of the surgical procedures twenty years ago.

It is interesting to note that there were only 31 appendectomies, a most common procedure in most hospitals, which should be compared with the 168 heart operations, *not* a common procedure in most hospitals. An appendectomy averages about 30 minutes of time and requires five people — the surgeon, assistant, anesthetist, scrub nurse and circulating nurse. A heart operation averages three hours and requires nine people — a surgeon, two assistant surgeons, anesthetist (sometimes two anesthetists), a nurse or technician to run the pump, a scrub nurse and two circulating nurses. The surgical equipment needed to perform an appendectomy is relatively simple. A heart operation requires considerable sophisticated and complicated equipment costing thousands of dollars. It is the average number of unusual and complicated cases sent to the Deaconess Hospital which in recent years has been reflecting in hospital costs.

It is interesting to note that twenty years ago we performed almost the same number of procedures as twenty years later (5,513 in 1951 — 5,965 in 1971) yet the budget increased from \$159,105 to \$780,000 or 390 per cent.

The cost of postoperative care also has increased. Twenty years ago we did not have a Recovery Room or an Intensive Care Unit. Immediately after surgery, the patient was taken to his room. Today, without a Recovery Room and Intensive Care Unit, we could not successfully treat many of our major surgical cases. The Recovery Room demands 28 personnel; the Intensive Care Unit, 52 personnel. The annual cost of running the Recovery Room is \$635,000. The 1972 budget for the Intensive Care Unit is \$1,645,000.

The Department of Surgery is well aware of and concerned about the rising cost of surgical care. Organ (other than kidney) transplantation may soon become standardized procedure. Newer and more complicated surgical equip-

ment is sure to be developed. The public will demand the best medical care available and it will be our responsibility, as in the past, to provide it.

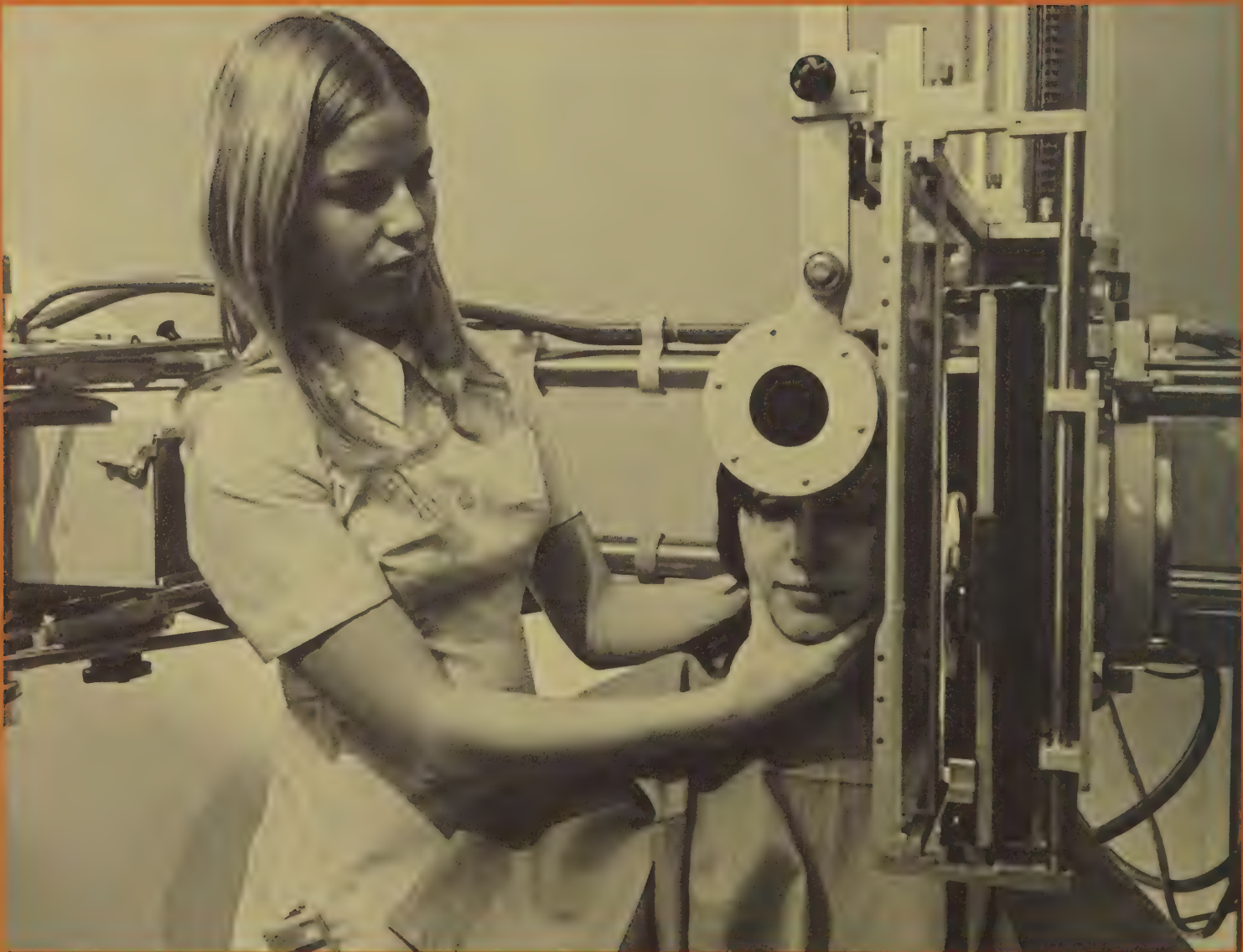
Owing to construction and building, the last year has been difficult for the Surgical Department. Operating Rooms had to be closed for renovation; scheduling of cases was difficult. The Recovery Room was moved to Deaconess 4 while the Central 4 location was enlarged and renovated. The problem of dust and contamination resulting from construction caused concern for fear of increasing infection. In spite of these difficulties, we performed about 600 more surgical procedures than last year.

I wish to thank the entire Surgical Staff — doctors, nurses, technicians, aides and orderlies — for their help, cooperation, and understanding during this transition period.



REPORT OF THE DEPARTMENT OF RADIOLOGY

Mirle A. Kellett, M.D.
Chairman



Each year for the last three years the annual report has anticipated the addition to the Central Building. At this writing, we are still anticipating but the end is at last truly in sight. The floors are being completed and occupied from the top downwards and, because our department is on a lower floor, for the last six months our volume of work has progressively increased without our expanded facilities. This year we performed 31,000 examinations as contrasted with 27,000 last year and the expectation is for between 35,000 and 37,000 examinations next year.

Mere numbers do not tell the whole story. The patients being examined are more seriously ill than in the past and require more specialized and time consuming studies. Part of this is owing to the basic nature of the Deaconess Hospital which is known for its ability to care for such cases. Another reason is the state of the economy. People with less serious problems are deferring hospitalization because of high costs and uncertainty concerning the future.

We are naturally looking forward to the installation of two new diagnostic rooms. When the equipment was ordered, two years ago, we decided to purchase 480 volt, 3-phase 12-pulse equipment. The first cost of such equipment is slightly higher, but radiation characteristics are such that the patient receives less radiation per exposure. It is of interest that an inter-society Commission for Heart Disease Resources, created through a contract with the Regional Medical Programs, has just recommended this type of equipment for examination of the heart and lungs. With three X-ray units using 3-phase 12-pulse systems, the Deaconess will remain in the forefront of Radiologic Diagnosis.



In a hospital such as the Deaconess with a large volume of heart and lung surgery, many portable X-rays are required during the immediate post-operative period. The patients are too ill to come to the Department for examinations, so we must go to them. In the past, portable X-rays were of poor quality because of their low output. Recently a battery operated unit has been developed with a higher output and, consequently, greatly improved films. A secondary benefit of great importance is the absence of electrical hazard caused by improper grounding.

After 23 years, we are giving up the small survey films of both patients and personnel. These survey films, similar to those taken by the Mobile Chest Units which went from town to town, have outlived their usefulness. The incidence of tuberculosis is decreasing so that the finding of positive cases is very low. Secondly, the X-ray dose to the patient needed to produce a survey film is very high. The Bureau of Radiation Protection of the Public Health Service has recommended the abolition of these survey units

because of the very high radiation levels.

For a number of years, Radiologists have been concerned about the number and quality of young doctors entering the field of Radiology. Suddenly, Radiology has come into its own and its place in medicine is being recognized by more young doctors. We have interviewed more and better qualified candidates than in the previous decade. This is encouraging for the future of Radiology.

I wish to thank our professional staff and personnel who have remained unchanged despite the difficult working conditions. This stability has allowed us to function smoothly and more efficiently to the ultimate benefit of the patient.

REPORT OF THE DEPARTMENT OF PATHOLOGY

William A. Meissner, M.D.
Chairman



There has been a steady emphasis on preparation for the future in our laboratories during 1971. Many of the exciting discoveries of the Space Age have now been turned to benefit hospital patients.

A new electron microscope has been installed in Palmer VI. This instrument, besides opening up new horizons for the diagnosis of tissue removed at surgery, will stimulate research activities and may open the door to the diagnosis of certain virus agents.

Equally exciting has been the shift in the daily work pattern from an eight-hour day, five-day week to a ten-hour day, four-day week. This experimental change maintains and actually augments our customary seven-day week laboratory coverage. Ours is the largest medical laboratory in the United States to try this approach, which is designed to give more complete support for patient care as well as provide an extra day of time off for regular workers and thus make their overall life pattern more pleasant.

Along with all other departments in the hospital, we have felt the surge of new activity due to hospital expansion, new techniques in laboratory diagnosis, the increasing severity of patients' illnesses, and the increasing complexity of surgical procedures. One way to meet this new challenge is to use the hospital computer for reporting laboratory information. Such use is now in its final development stage and with the excellent cooperation of the Data-Processing Department significant progress has been made.

It is incredible to think that a new machine in the chemistry laboratory analyzes a relatively small

sample of blood for 18 different chemical substances in much less time than it used to take to do only one of the tests manually, and at a fraction of the cost. This instrument has enormously increased the capacity of our laboratory to provide rapid information about each patient. The utilization of this instrument is more efficient with a large volume and so its availability to nearby institutions is beneficial to everybody. Similar instruments useful in blood cell studies result in the same kind of benefits.

One of the most innovative developments of the hospital renovation is the new Admissions Laboratory which will be visited by each patient as he enters the hospital. In this laboratory blood samples can be taken and processed immediately so that when a patient reaches the floor the physician will have laboratory information available to him. This will speed up both the diagnosis and the treatment and allow a more productive use of the patient's time in the hospital.

Due to such innovations, our training programs must continue to expand. Our program for medical technologists is now in the transition period toward a new concept. Our Blood Bank is developing a School for Blood Bank Technology which will be the first in New England.



During the year we were sorry to have Dr. Joseph C. Parker, Jr., leave our department. We wish him success in his new position as head of surgical pathology at the University of Kentucky Medical School. We welcome Dr. Bernard F. Mann, Jr., formerly of New Haven and an alumnus of our training program, as an addition to our staff.

We are all very proud of the high honor bestowed upon Dr. Bradley E. Copeland during the annual meeting of the American Society of Clinical Pathologists when he was presented with the Ward Burdick Award "in recognition of his meritorious contributions to the science of clinical pathology."



REPORT OF THE JOINT CENTER FOR RADIATION THERAPY

Samuel Hellman, M.D.
Chairman



During the third year of operation for the Joint Center for Radiation Therapy, 1,461 new patients were seen, approximately 10 per cent more than last year. Of the new patients, 475 were seen at the New England Deaconess Hospital.

The member hospitals in the Joint Center for Radiation Therapy have increased, in two categories. The Children's Hospital Medical Center has formally joined and brings the number of full members to five. In addition, a new category of Associate Member has been made for hospitals more peripheral to the Longwood area with Faulkner Hospital being the first member to accept this role.

To meet an increasing patient load and hospital responsibilities, Dr. J. Robert Cassady has joined the staff which increases the number of consultant radiation therapists to eight. The total technical, professional and administrative personnel of the Center numbers 43. The physical equipment at the Joint Center is now being maximally used. The three 4-MeV linear accelerators are active and filled to capacity. The 6-MeV accelerator presently at the Peter Bent Brigham Hospital is being retired and will be replaced with a new 12-MeV linear accelerator to be delivered in March 1972. Until that becomes operational, the department's treatment facilities are being excessively taxed.

The Treatment Planning Center at the Parkway Division of the Boston Hospital for Women is almost completed and should be operational by the middle of November. This center will allow patients from all member hospitals of the Joint Center to have their treatment plans determined and simulated on special devices to ensure the accuracy of treatment.

Most patients will visit the Treatment Planning Center on at least one occasion and some twice. A few patients with relatively simple treatment techniques will not require a visit to the Treatment Planning Center.

Our teaching activities have greatly increased this last year. We have been the recipients of a National Institutes of Health grant for training radiotherapists and radiation therapy technologists. Seven residents in radiation therapy have entered this program making it the largest training program for radiation therapy in the New England area. The technology school has begun and we currently have two technologists in training.

Research activities of the Joint Center are performed primarily in the Shields Warren Radiation Laboratory. The active areas under investigation have been: 1) The response of single cells to ionizing radiation and the influence of post-irradiation conditions on such damage; 2) Study of the hematopoietic stem cells as an important normal tissue, specifically with concern for the influence of irradiation and chemotherapeutic agents on this cell renewal tissue; 3) The basic immunologic studies of tumors both in the experimental animal and the human; 4) Studies of the *in vivo* growth and pathophysiology of a transplanted ovarian tumor in mice, and 5) Research and development on ways of making new linear accelerators maximally useful for our patients.

Some of the highlights of these important activities may be listed briefly:

1) Dr. James A. Belli has been studying the survival characteristics of mammalian cells in culture. He has found that daughter cells of radiation damaged precursors can be made to repair such damage if placed into suitable post-irradiation conditions. These results are important since they demonstrate the activities of repair systems present not only in the cells irradiated but in the progeny of these cells as well.

Further, they indicate that heritable radiation injury is reparable. Such data have practical importance if we are to understand the late effects of radiation in patients. Other studies have been concerned with the interaction of the important chemotherapeutic agent Actinomycin D. with radiation. This drug has been shown clinically to cause increased reaction in irradiated areas, and it is hoped that these studies will allow us to capitalize on this unique combination.

Studies on the generic material removed from these cells after irradiation has been another area of interest of Dr. Belli's. He has described the changes in this generic material (DNA) following irradiation and a variety of post-irradiation conditions. It is hoped that from such data insight may be gained into the basic molecular mechanisms of radiation damage and repair.

2) The study of biology and kinetics of the most primitive hematopoietic cells has been an area of active investigation by both Drs. Samuel Hellman and John T. Chaffey. Recent work has further amplified their findings that cells in different positions in the cell cycle have quite different responses to radiation. They have further shown that cells which survive radiation and especially the chemotherapeutic agents nitrogen mustard and cyclophosphamide produce different kinds of progeny. Usually such hematopoietic stem cells can give rise to both white blood cells as well as red blood cells. Following treatment by these drugs or radiation, however, the ability to produce red blood cells is markedly impaired. Thus, such agents not only kill cells, they change the patterns of differentiation of those which survive.

New data on the drug nitrogen mustard has indicated that this potent agent is similar to X-ray in that cells in different phases of the cell cycle have different sensitivities. However, the sensitivities to nitrogen mustard do not parallel X-ray. Further, unlike with X-ray, cells treated with nitrogen mustard have no appreciable ability to repair such damage. These studies, we feel, will be important in allowing better methods of utilizing this drug in the clinic.



3) The tumor immunology activities have been very exciting this year in that Drs. Stanley E. Order, Stanley E. Chism, and Samuel Hellman have demonstrated an antigen present in the spleens of patients with Hodgkin's disease not present in significant amounts in the spleens of normal patients. This tumor-associated antigen allowed for the first time an immunologic market of this disease. The finding was reported as a lead article in the *New England Journal of Medicine* and has resulted in widespread interest throughout the medical community. Illucidation of the nature of these tumor-related antigens is currently being intensively sought. An animal model for these tumor immunology studies is also being actively studied in collaboration with Dr. Robert C. Knapp Department of Obstetrics and Gynecology at Beth Israel Hospital.

4) Studies on the biology of an experimental ovarian cancer have been rewarding. Dr. George Feldman, during his last year of medical school, worked in these laboratories with Drs. Hellman, Order, and Knapp and described the mechanism for the production of ascites in ovarian cancer. In this experimental tumor, it was shown that ascites is due to obstruction of the lymphatics which drain the abdomen and not due to primary over-production of ascitic fluid.

Further work on this ovarian tumor now permits understanding the ways in which this tumor grows. We are beginning to quantitate its growth as well as its immunologic interaction with the host and hope this will be a meaningful model for understanding human tumors.

5) The work of the physics group under Dr. Bengt Bjarngard on the new linear accelerators has resulted in new techniques for the delivery of the radiation dose at a depth with minimal damage to normal tissues. Further, a newly-designed filter for placement into the beam will allow a lower dose to the skin. The energy spectrum for the linear accelerators has not been well studied in the past. This spectrum is quite important if we are to understand the best ways of delivering radiation to the patient. Techniques for studying such primary spectra are actively being investigated in hope that primary spectra will be measured for all clinical machines.



SHIELDS WARREN RADIATION LABORATORY

NEW ENGLAND DEACONESS COMPLEX



The Medical Office Building at 110 Francis Street is known for the completeness of its available services and facilities. There the patient finds full diagnostic services, leading medical, surgical, and dental specialists, and overnight accommodations for prolonged stays. Most medical specialties are represented in the office building.

The Joslin Clinic Division of Joslin Diabetes Foundation, Inc., under the direction of Dr. Robert F. Bradley, maintains high standards of excellence in the treatment of diabetes and its various complications. Integrated with the clinic's out-patient services is the Deaconess Hospital Teaching Unit on the second floor of the Joslin Diabetes Foundation building. This unit, for ambulatory in-patient diabetics, increased its bed capacity during 1971 from 40 to 52. The Elliott P. Joslin Research Laboratory, directed by Dr. George F. Cahill, Jr., is on the third and fourth floors of the building.

The Lahey Clinic, founded by Dr. Frank H. Lahey in 1923, is now a division of the Lahey Clinic Foundation. It is one of the nation's oldest and most renowned diagnostic centers. Some 95 senior physicians and surgeons, 65 resident physicians and 100 nurses and technicians staff 17 specialized medical departments. Since its inception, the Lahey Clinic has maintained a close working relationship with the Deaconess Hospital where it hospitalizes many of its patients, utilizes surgery and laboratory services, and trains many of its residents.

The Overholt Thoracic Clinic maintains its place as a leader in the advancement of surgical treatment of the lungs, esophagus, heart and great vessels. Doctors trained at the clinic are located throughout the world, from the University of Cordoba, Argentina, to the University of Saigon, South Vietnam. Besides practicing thoracic surgery, these physicians participate fully in the research and education aspects of the field.

The Cancer Research Institute: Recognition of the importance of basic cancer research to the hospital led to the construction of the Cancer Research Institute in 1951 to house the expanding research programs of Dr. Shields Warren, its first scientific director. The Institute's contribution to understanding radiation carcinogenesis and tumor biology, especially tumor enzymology, over the twenty years of its existence are attested to by the publication of more than 546 scientific papers by its research staff. The Institute's importance in national and international cancer work is attested to by its membership in the Association of American Cancer Institutes and the International Union Against Cancer.

The staff of the Cancer Research Institute is engaged in cancer-related basic research projects. These range from studies of the changes in enzyme patterns, which can be induced in developing tissues by hormones, to studies of enzyme patterns in tumors and radiation carcinogenesis in rats, to a search for changes in bone cell metabolism which might be responsible for bone destruction in Multiple Myeloma. In addition, there has been an active program of teaching in radiobiology, and a number of pre-doctoral and post-doctoral Fellows from Harvard Medical School and Boston University are receiving training in various laboratories of the Institute and Boston University.

The research of the Institute is supported by grants and contracts from the U.S. Atomic Energy Commission, various institutes of the

National Institutes of Health, and private foundations such as the John A. Hartford Foundation, the American Cancer Society, the Damon Runyon Fund, the Elsa U. Pardee Foundation, and Aid for Cancer Research.

This year a core grant application was submitted to the National Cancer Institute for the establishment of a Cancer Research Center at the New England Deaconess Hospital to unify the diverse basic science and clinical cancer research projects current in the institution, and to add critically needed strength to important areas such as virology and immunology so that a multidisciplinary attack can be made on the questions of the origins, natural history and treatment of tumors, especially those which are hormone related by virtue of arising in endocrine glands, being susceptible to their secretions, or producing hormone-like substances.





A newly formed Cancer Research Center Committee, under the chairmanship of Dr. George Nichols, Jr., scientific director of the Cancer Research Institute, will have overall responsibility for the Center. The Center will carry out multidisciplinary cancer investigation at the New England Deaconess Hospital, covering the scope of endocrine related tumors from basic studies to clinical rehabilitation. It will combine the research activities of the Cancer Research Institute, the departments of medicine, pathology, radiation therapy and surgery, and the out-patient clinic and the Stoma Rehabilitation Clinic.

The Shields Warren Radiation Laboratory was opened in 1965 under the directorship of Dr. Henry I. Kohn. It is dedicated to the investigation of ionizing radiations, especially in relation to their use for diagnosis and treatment of cancer. X-rays, gamma rays from cobalt-60 or radium, and those generated by linear accelerators are examples of such radiation. The use of isotopes such as radioactive iodine also is based on such rays.

During the last year, the major research groups of the laboratory — organized under the rubrics of experimental therapy, diagnosis, nuclear medicine, pathology, biology, and reproduction — received grants in excess of \$500,000 for the direct costs of research that involved the equivalent of 75 full-time personnel.



The breadth of the program may be gauged from mention of the research problems that have been under continuing investigation: injury and recovery of cells following irradiation of bone marrow or tissue culture; factors that influence the radiologic induction of leukemia; the radiologic and chemical induction of mutations in the mouse; the changes that occur in DNA *in vivo* following irradiation and the speed with which such changes are repaired; the chemical changes that occur in the constituent amino acids of irradiated proteins, and the pharmacology of the vasculature as a basis for enhancing the efficiency of X-ray examinations.

Three results of this program that have special clinical relevance or promise may be mentioned: a new radioactive pharmaceutical compound (TcFHMA) has been developed and introduced into practice for the diagnostic examination of the lung; patients with Hodgkin's disease have been shown by laboratory test to share a com-

mon specific antigen; the blood vessels within liver cancer (in the experimental animal) fail to respond to certain drugs that contact the vessels in normal regions.

In addition to its experimental goals, the laboratory aims to bring together practicing clinicians with experimentalists, students, and trainees to promote research training and discussion in relation to clinical practice. There are weekly seminars and conferences.

Finally, the Shields Warren Radiation Laboratory provides the Joint Center for Radiation Therapy with its administrative and scientific headquarters. Members of the Center's staff are in charge of radiation therapy at the Deaconess and the other Harvard-affiliated hospitals in this area (Beth Israel Hospital, Boston Hospital for Women, Children's Hospital Medical Center, and Peter Bent Brigham Hospital.)



REPORT OF THE FRIENDS OF DEACONESS

Mrs. Lauriston Ward, Jr.
President



During Fiscal 1971 the Friends of the Deaconess Hospital raised a total of \$47,025.78 through their various activities. The figures for each activity are shown below, along with the gain or loss in dollars compared with Fiscal 1970.

Memberships	\$ 2,448.00	— 167
Membership Gifts	934.00	+ 341
Memorial Fund	1,110.00	+1059
Church Gifts	627.00	— 21
Thrift Shop	17,192.05	+ 219
Coffee Shop	19,350.00	—5700
Flower Shop	549.03	— 289
Christmas Bazaar	2,247.07	— 65
Pops Concert	1,739.00	— 4
Other	829.63	— 968
TOTAL	\$47,025.78	—5595

The greatest single decline in revenue, experienced by the Coffee Shop, deserves comment. While the Coffee Shop, in addition to the \$19,350 turned over to the Friends, also was able to grant its usual annual Nursing School Scholarship of \$3,300, it faces two problems which are likely to increase in coming years. The first is the steady rise in food prices. The second is that, faced with a dearth of volunteers, the Coffee Shop gradually has had to increase the number of paid workers. Last year, the monthly payroll averaged \$3,200. If these trends continue, the Coffee Shop may eventually become a non-profit service to the hospital.

Fortunately, another Friends' project, which could make no cash contribution last year, has shown the potential for greatly increasing its contribution to the treasury.



This is the Gift Shop. After opening on September 21, 1970, in its new and attractive quarters off the Central Building lobby, with items purchased with borrowed funds, the Gift Shop took in more than \$60,000 in sales to October 1, 1971. The figure represents a dramatic increase over sales in the former shop and there is every indication that the revenues will continue to climb. Naturally, profits from these 12 months of operation were reinvested in order to bring the inventory up to a point where it can sustain a continued growth. That point, however, has almost been reached and operations in the coming year ought to allow a substantial contribution to the Friends' commitments to the hospital.

One further commentary on the last year's activities would seem to be in order. Because rising ticket prices have steadily diminished the fund-raising value of the Deaconess Night at Pops, the Board of the Friends last year voted to discontinue this activity. Instead, a direct appeal was mailed to all Friends

urging a contribution in support of nurses' scholarships. It is significant, we think, that response to the appeal fell just \$4.00 short of the funds raised the year before.

As this is my third and last report as President of the Friends, perhaps it would be appropriate to conclude with some general observations on the work of this organization.

It is noteworthy, I think, that over the years the mission, organization and activities of the Friends have largely remained unchanged. The major focus always has been on fund raising for the hospital, through projects conceived and executed by volunteers.

These last three years have represented for me an opportunity for which I am profoundly grateful. No hospital administration could possibly have been more gracious and supportive of our work. I leave, therefore, with regret, but in the knowledge that my successor, Mrs. James T. Mountz, will find her experience as President equally rewarding.



NEW ENGLAND DEACONESS HOSPITAL

BALANCE SHEET

SEPTEMBER 26, 1971

AND

SEPTEMBER 27, 1970

	— ASSETS —		1971	1970
	<u>UNRESTRICTED FUNDS</u>			
CURRENT ASSETS:				
Cash	\$	180,099	\$	1,136
Temporary cash investments		228,318		1,146,184
Accounts receivable (less allowance for uncollectible accounts: 1971, \$280,049; 1970, \$306,329)		3,325,329		2,356,587
Grants receivable		440,818		40,818
Inventories of supplies — at cost		262,098		256,753
Prepaid expenses		164,577		40,275
Total current assets		4,601,239		3,841,753
PROPERTY, PLANT, AND EQUIPMENT — At cost (Note 1):				
Construction in progress		389,999		7,194,869
Land, buildings, and equipment — less accumulated depreciation: 1971, \$8,320,885; 1970, \$7,458,462 (Note 2)		17,983,818		8,362,444
Total property, plant, and equipment		18,373,817		15,557,313
TOTAL		<u>\$22,975,056</u>		<u>\$19,399,066</u>
		<u>RESTRICTED FUNDS</u>		
SPECIAL PURPOSE FUNDS:				
Cash	\$	177,850	\$	609,474
Investments — at cost (market value: 1971, \$584,000; 1970, \$246,000)		486,694		246,860
Due from Unrestricted Funds		395,000		
Grants receivable		334,851		316,203
Total special purpose funds	\$	1,394,395	\$	1,172,537
ENDOWMENT FUNDS:				
Cash	\$	7,870	\$	2,593
Investments — at cost or contributed value (market value: 1971, \$2,740,000; 1970, \$2,359,000)		2,037,824		2,020,703
Real estate, equipment, and furnishings — at cost, less accumulated depreciation: 1971, \$976,724; 1970, \$855,629 (Note 1)		4,674,668		4,798,883
Due from Unrestricted Funds		52,398		20,160
Total endowment funds	\$	6,772,760	\$	6,842,339
PLANT REPLACEMENT AND EXPANSION FUNDS:				
Temporary cash investments, etc.	\$	28,092	\$	210,080

See notes to financial statements.

LIABILITIES AND — FUND BALANCES —		1971	1970
<u>UNRESTRICTED FUNDS</u>			
CURRENT LIABILITIES:			
Accounts payable and accrued expenses	\$ 2,092,784	\$ 1,737,990	
Deferred revenue	207,845	169,816	
Current mortgage note instalments (Note 1)	85,681	82,338	
Due to Restricted Funds	447,398	20,160	
Total current liabilities	2,833,708	2,010,304	
DEFERRED REVENUE — Third-party reimbursement (Note 2)	368,000	259,500	
MORTGAGE NOTE PAYABLE (Note 1)	537,150	622,831	
NOTES PAYABLE TO BANK (Note 1)	1,865,000		
FUND BALANCES (Note 4)	17,371,198	16,506,431	
TOTAL		<u>\$22,975,056</u>	<u>\$19,399,066</u>
<u>RESTRICTED FUNDS</u>			
SPECIAL PURPOSE FUNDS:			
Accumulated gifts, bequests, and reserves for special purposes	\$ 1,078,337	\$ 846,791	
Unexpended research grants	316,058	325,746	
Total special purpose funds	\$ 1,394,395	\$ 1,172,537	
ENDOWMENT FUNDS:			
Mortgage notes payable (Note 1)	\$ 2,965,320	\$ 3,051,946	
Fund balances	3,807,440	3,790,393	
Total endowment funds	\$ 6,772,760	\$ 6,842,339	
PLANT REPLACEMENT AND EXPANSION FUNDS:			
Fund balance	\$ 28,092	\$ 210,080	

See notes to financial statements.

STATEMENT OF REVENUES AND EXPENSES

FOR THE FISCAL YEARS
ENDED SEPTEMBER 26, 1971 AND
SEPTEMBER 27, 1970

	1971	1970
PATIENT SERVICE REVENUE	\$19,935,922	\$15,908,092
LESS — Free care, provision for uncollect- ible accounts, contractual adjustments, etc.	560,742	293,011
NET PATIENT SERVICE REVENUE	19,375,180	15,615,081
OTHER OPERATING REVENUE — Transfer from special purpose funds	977,452	705,120
TOTAL OPERATING REVENUE	20,352,632	16,320,201
OPERATING EXPENSES:		
Professional care of patients:		
General	6,138,500	4,851,319
Special	6,354,600	5,390,148
Household and property	2,677,797	2,286,667
General services and administration	2,572,925	1,886,629
Employee benefits (Note 3)	1,422,985	869,038
Depreciation (straight-line basis)	802,789	557,789
Research, etc.	977,452	705,120
Total operating expenses	20,947,048	16,546,710
LOSS FROM OPERATIONS	594,416	226,509
INTEREST EXPENSE	76,410	29,660
LOSS BEFORE NON-OPERATING REVENUE	670,826	256,169
NON-OPERATING REVENUE:		
From endowment funds	144,038	181,763
Donations and other distributions (net of development expense)	72,879	88,730
From temporary investments, etc.	39,541	63,418
Total non-operating revenue	256,458	333,911
EXCESS (DEFICIENCY) OF REVENUES OVER EXPENSES	\$ (414,368)	\$ 77,742

See notes to financial statements.

STATEMENT OF CHANGES IN FUND BALANCES

FOR THE FISCAL YEAR
ENDED SEPTEMBER 26, 1971

	RESTRICTED FUNDS			
	Unrestricted Funds	Special Purpose Funds	Endowment Funds	Plant Replacement And Expansion Funds
BALANCE AT BEGINNING OF YEAR (Note 4)	\$16,506,431	\$1,172,537	\$3,790,393	\$ 210,080
INCREASES (DECREASES):				
Legacies, gifts, etc.	126,186	244,084	41,420	216,891
Central Building Fund receipts				467,782
Grants for specified purposes		797,603		400,000
Net loss on sales of investments			(24,373)	
Investment income		21,828		6,124
Excess of expenses over revenues for the year	(414,368)			
Transfer to other operating revenue		(977,452)		
Other — net		14,835		1,124
Total	16,218,249	1,273,435	3,807,440	1,302,001
INTERFUND TRANSFERS:				
Legacies restricted for special purposes	(126,186)	126,186		
Investment in build- ings and equipment . . .	1,279,135	(5,226)		(1,273,909)
BALANCE AT END OF YEAR	\$17,371,198	\$1,394,395	\$3,807,440	\$ 28,092

See notes to financial statements.

NOTES TO FINANCIAL STATEMENTS
FOR THE FISCAL YEAR ENDED
SEPTEMBER 26, 1971

1. LONG-TERM DEBT AND CONSTRUCTION IN PROGRESS

The mortgage notes payable by the Hospital are due in instalments which (1) as to the unrestricted funds note aggregate \$109,320 annually, to February 1978 and (2) as to the two endowment funds notes aggregate \$244,832 annually, including interest, to February 1991. The Hospital's land and buildings, with the exception of research buildings and certain staff residences, are assigned under these mortgages.

Notes payable to bank represent temporary financing in connection with the completion of the Hospital's Central building addition, the costs of which were transferred from construction in progress to land, buildings, and equipment during the year. These notes have been classified as long-term because the Hospital has a mortgage loan commitment whereby these notes and two of the existing mortgage notes payable (aggregating \$973,265 at September 26, 1971) are to be refinanced during 1971 through a new 25-year mortgage note in the amount of \$3,632,000.

Construction in progress at September 26, 1971 includes costs of approximately \$170,000 for a new parking garage. Further construction commitments for this facility aggregated approximately \$2,300,000 at that date. This construction is to be financed in part by funds obtained through the aforementioned mortgage loan commitment.

2. LAND, BUILDINGS, AND EQUIPMENT

Land, buildings, and equipment are stated at cost and depreciation is provided on the straight-line basis.

Under certain third-party reimbursement agreements, the Hospital uses accelerated depreciation to determine reimbursable costs and defers the revenue attributable to the excess of such depreciation over straight-line depreciation. Revenue thus deferred for the fiscal year ended September 26, 1971 was \$108,500.

3. EMPLOYEES' RETIREMENT PLAN

Effective September 28, 1970, the Hospital adopted a new non-contributory retirement plan covering substantially all employees not over age 55 at date of employment. This plan supercedes a contributory retirement plan which covered substantially all employees who had reached age 30. Under the new plan the Hospital provides amounts necessary to cover current costs and amortization of prior service cost over 40 years. The provision for the year ended September 26, 1971 was approximately \$368,000, all of which had been

paid to the plan trustee at that date. The provision for the year ended September 27, 1970 was approximately \$154,000.

4. RECLASSIFICATION OF PRECEDING YEAR'S AMOUNTS

The accompanying financial statements present the accounts of the Hospital in general accordance with the presentation suggested by recent tentative pronouncements of the Committee on Health Care Institutions of the American Institute of Certified Public Accountants. The principal changes from prior reporting practices include presenting the balance sheet in the two basic fund accountabilities of unrestricted and restricted funds, and reporting research expenditures in the statement of revenues and expenses. The Hospital, however, has continued its consistent practice of recording unrestricted legacies and gifts as credits directly to the balance of unrestricted funds and of subsequently transferring such amounts, after appropriate designation, to special purpose funds. For purposes of comparison, certain preceding year's amounts in the balance sheet and statement of revenues and expenses reflect reclassification of amounts previously reported.

ACCOUNTANTS' OPINION

New England Deaconess Hospital:

We have examined the balance sheet of New England Deaconess Hospital as of September 26, 1971 and the related statements of revenues and expenses and changes in fund balances for the fiscal year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying financial statements present fairly the financial position of New England Deaconess Hospital at September 26, 1971 and the results of its operations for the fiscal year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year (after reclassification of certain preceding year's amounts as explained in Note 4).

Boston, Massachusetts
November 12, 1971

Haskins & Sells

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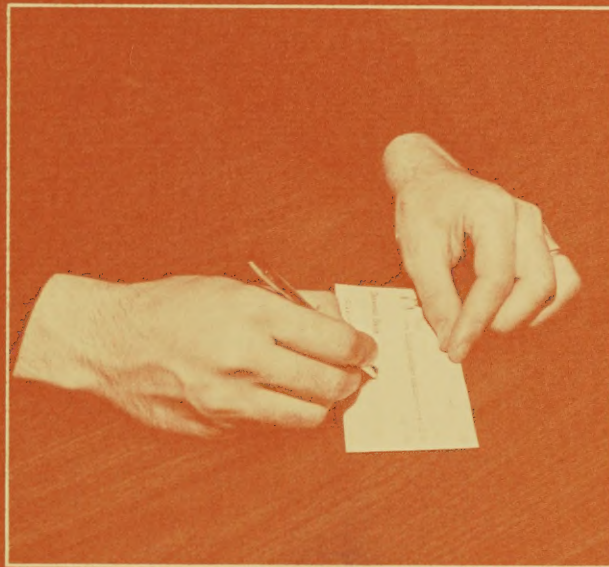
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